FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031765

Facility Name: BRIAR PLACE, LTD.

Address: 6800 W JOLIET ROAD (Number) INDIAN HEAD PARK CITY (City) 60525 (Zip Code)

County: COOK

Telephone Number: (708) 246-8500 **Fax #** (708) 246-0086

IDPA ID Number: 36-3472799-001

Date of Initial License for Current Owners: 11/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	EDWARD N. SLACK, C.P.A.
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,208	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	52,704	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,912	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,899	3,349	3,224	27,472	8
9	SNF/PED					9
10	ICF	40,569	6,798	440	47,807	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,468	10,147	3,664	75,279	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.66%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,432

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	287,572	45,899	19,466	352,937		352,937	(10,271)	342,666			1
2	Food Purchase		264,728		264,728		264,728	2,814	267,542			2
3	Housekeeping	202,194	54,276		256,470		256,470	2,673	259,143			3
4	Laundry	118,728	27,578		146,306		146,306		146,306			4
5	Heat and Other Utilities			188,674	188,674		188,674	2,051	190,725			5
6	Maintenance	141,157		150,612	291,769		291,769	(173)	291,596			6
7	Other (specify):*							2,791	2,791			7
8	**TOTAL General Services**	749,651	392,481	358,752	1,500,884		1,500,884	(115)	1,500,769			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,999,669	82,637	176,930	2,259,236		2,259,236	17,860	2,277,096			10
10a	Therapy	51,419	1,385	12,740	65,544		65,544	2,237	67,781			10a
11	Activities	121,000	11,327	6,096	138,423		138,423	(1,144)	137,279			11
12	Social Services	141,353		5,939	147,292		147,292	(3,549)	143,743			12
13	Nurse Aide Training											13
14	Program Transportation			26,917	26,917		26,917		26,917			14
15	Other (specify):*							11,862	11,862			15
16	**TOTAL Health Care and Programs**	2,313,441	95,349	237,622	2,646,412		2,646,412	27,267	2,673,679			16
	C. General Administration											
17	Administrative	42,284		58,187	100,471		100,471	43,275	143,746			17
18	Directors Fees											18
19	Professional Services			375,154	375,154	(15,000)	360,154	(316,093)	44,061			19
20	Dues, Fees, Subscriptions & Promotions			111,626	111,626		111,626	(43,819)	67,807			20
21	Clerical & General Office Expenses	107,334	25,850	199,857	333,041		333,041	(2,899)	330,142			21
22	Employee Benefits & Payroll Taxes			600,083	600,083		600,083	(25,986)	574,097			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,481	9,481		9,481	5,949	15,430			24
25	Other Admin. Staff Transportation			16,004	16,004		16,004	(14,532)	1,472			25
26	Insurance-Prop.Liab.Malpractice			103,852	103,852		103,852	1,365	105,217			26
27	Other (specify):*							29,796	29,796			27
28	**TOTAL General Administration**	149,618	25,850	1,474,244	1,649,712	(15,000)	1,634,712	(322,945)	1,311,767			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,212,710	513,680	2,070,618	5,797,008	(15,000)	5,782,008	(295,793)	5,486,215			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

BRIAR PLACE, LTD.
0031765
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS		
2	FOOD		

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	15,000	
19	PROFESSIONAL FEES		15,000

To reclass cost of appealing real estate taxes

Facility Name & ID Number BRIAR PLACE, LTD. #0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			104,102	104,102		104,102	323,354	427,456			30
31	Amortization of Pre-Op. & Org.			1,290	1,290		1,290	1,678	2,968			31
32	Interest			12,526	12,526		12,526	904,728	917,254			32
33	Real Estate Taxes			238,393	238,393	15,000	253,393	2,777	256,170			33
34	Rent-Facility & Grounds			942,530	942,530		942,530	(937,220)	5,310			34
35	Rent-Equipment & Vehicles			5,826	5,826		5,826	4,379	10,205			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,304,667	1,304,667	15,000	1,319,667	299,696	1,619,363			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,011	85,542	160,553		160,553	(243)	160,310			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,368	127,368		127,368		127,368			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		75,011	212,910	287,921		287,921	(243)	287,678			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,212,710	588,691	3,588,195	7,389,596		7,389,596	3,660	7,393,256			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,769)	30		9
10	Interest and Other Investment Income	(7,360)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(353)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(123,173)	21		24
25	Fund Raising, Advertising and Promotional	(20,787)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,550)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,728)	20		28
29	Other-Attach Schedule	(2,096)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (174,816)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	178,476		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 178,476		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 3,660		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BRIAR PLACE, LTD.

ID# 0031765

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	COLLECTION EXP.	(1,309)	21	2
3	MISC INCOME	(34)	21	3
4	POLITICAL CONT. COPE	(317)	20	4
5	UNIFORMS - MISC INCOME	(24)	10	5
6	JURY DUTY	(52)	10	6
7	1999 LEGAL FEES	(360)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
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87				87
88				88
89				89
90	Total	(2,096)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			6,379	(8,606)		(8,043)						(10,271)	1
2	Food Purchase	(353)		(1,357)			4,524						2,814	2
3	Housekeeping			2,673									2,673	3
4	Laundry													4
5	Heat and Other Utilities			2,051									2,051	5
6	Maintenance			16,781	(16,975)		21						(173)	6
7	Other (specify):*			2,568			223						2,791	7
8	**TOTAL General Services**	(353)		29,095	(25,582)		(3,275)						(115)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(76)		32,367	(57,615)	47,834	3		(4,653)				17,860	10
10a	Therapy			6,252	(4,015)								2,237	10a
11	Activities			2,712	(3,856)								(1,144)	11
12	Social Services			2,390	(5,939)								(3,549)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,578		6,284							11,862	15
16	**TOTAL Health Care and Programs**	(76)		49,299	(71,424)	54,118	3		(4,653)				27,267	16
	C. General Administration													
17	Administrative			43,157	(58,187)	58,187	118						43,275	17
18	Directors Fees													18
19	Professional Services	(360)		11,363	(327,131)		35						(316,093)	19
20	Fees, Subscriptions & Promotions	(23,832)		1,668	(21,664)		9						(43,819)	20
21	Clerical & General Office Expenses	(130,066)		153,704	(26,654)		117						(2,899)	21
22	Employee Benefits & Payroll Taxes				(25,986)								(25,986)	22
23	Inservice Training & Education													23
24	Travel and Seminar			5,942			7						5,949	24
25	Other Admin. Staff Transportation			264	(15,000)		204						(14,532)	25
26	Insurance-Prop.Liab.Malpractice			1,365									1,365	26
27	Other (specify):*			22,708		7,088							29,796	27
28	**TOTAL General Administration**	(154,258)		240,171	(474,623)	65,275	490						(322,945)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(154,687)		318,565	(571,629)	119,393	(2,782)		(4,653)				(295,793)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(12,769)	321,783	14,340									323,354	30
31	Amortization of Pre-Op. & Org.		1,678										1,678	31
32	Interest	(7,360)	896,554	15,527			7						904,728	32
33	Real Estate Taxes			2,777									2,777	33
34	Rent-Facility & Grounds		(942,530)	5,310									(937,220)	34
35	Rent-Equipment & Vehicles			4,369			10						4,379	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(20,129)	277,485	42,323			17						299,696	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(243)						(243)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(243)						(243)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(174,816)	277,485	360,888	(571,629)	119,393	(3,008)		(4,653)				3,660	45

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTATCHED		SEE ATTATCHED		SEE ATTATCHED		
				GWH LIMITED PARTNERSHIP		BLDG PARTNER

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest Expense	$	GWH Limited Partnership		$ 896,554	$ 896,554	1
2	V	30	Depreciation Expense		GWH Limited Partnership		321,783	321,783	2
3	V	31	Amortization		GWH Limited Partnership		1,678	1,678	3
4	V	34	Rental Income	942,530	GWH Limited Partnership			(942,530)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 942,530			$ 1,220,015	$ * 277,485	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 6,379	$ 6,379	15
16	V	2	FOOD				(1,357)	(1,357)	16
17	V	3	HOUSEKEEPING				2,673	2,673	17
18	V	5	UTILITIES				2,051	2,051	18
19	V	6	REPAIRS AND MAINT.				16,781	16,781	19
20	V	7	EMP. BEN. - GEN. SERV.				2,568	2,568	20
21	V	10	NURSING				32,367	32,367	21
22	V	10A	THERAPY				6,252	6,252	22
23	V	11	ACTIVITIES				2,712	2,712	23
24	V	12	SOCIAL SERVICES				2,390	2,390	24
25	V	15	EMP. BEN. - HEALTHCARE				5,578	5,578	25
26	V	17	ADMINISTRATIVE				43,157	43,157	26
27	V	19	PROFESSIONAL FEES				11,363	11,363	27
28	V	20	DUES, SUBSCRIPTIONS				1,668	1,668	28
29	V	21	CLERICAL AND GENERAL				153,704	153,704	29
30	V	24	SEMINARS				5,942	5,942	30
31	V	25	AUTO EXPENSE				264	264	31
32	V	26	INSURANCE				1,365	1,365	32
33	V	27	EMP. BEN. - GEN. ADMIN.				22,708	22,708	33
34	V	30	DEPRECIATION				14,340	14,340	34
35	V	32	INTEREST	0			15,527	15,527	35
36	V	33	REAL ESTATE TAXES				2,777	2,777	36
37	V	34	BUILDING RENT - UNRELATED				5,310	5,310	37
38	V	35	EQUIPMENT RENTAL				4,369	4,369	38
39	Total			$			$ 360,888	$ * 360,888	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 8,606	CARE CENTERS, INC.	100.00%	$ 0	$ (8,606)	15
16	V	19	ACCOUNTING	15,000			0	(15,000)	16
17	V	19	ANCIL ADMIN FEE	28,295			0	(28,295)	17
18	V	19	BOOKEEPING	48,102			0	(48,102)	18
19	V	19	DATA PROCESSING	8,489			0	(8,489)	19
20	V	19	LEGAL	21,516			0	(21,516)	20
21	V	19	MANAGEMENT FEE	198,065			0	(198,065)	21
22	V	19	PROFESSIONAL FEES	7,665			0	(7,665)	22
23	V	20	ADVERTISING	21,664			0	(21,664)	23
24	V	25	REBILL BUS	15,000			0	(15,000)	24
25	V	0					0		25
26	V	22	HOME OFFICE PAYROLL TAX	25,986			0	(25,986)	26
27	V	1	REBILL. PAYROLL DIETARY	0			0		27
28	V	3	REBILL. PAYROLL HSKPNG	0			0		28
29	V	6	REBILL. PAYROLL MAINT.	16,975			0	(16,975)	29
30	V	10	REBILL. PAYROLL NURSING	57,615			0	(57,615)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	4,015			0	(4,015)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	3,856			0	(3,856)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	5,939			0	(5,939)	33
34	V	17	REBILL. PAYROLL ADMIN.	58,187			0	(58,187)	34
35	V	21	REBILL. PAYROLL CLERICAL	26,654			0	(26,654)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 571,629			$ 0	$ * (571,629)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 47,834	$ 47,834	15
16	V	15	EMP. BEN HEALTHCARE				6,284	6,284	16
17	V	17	ADMINISTRATIVE				58,187	58,187	17
18	V	27	EMP. BEN GEN. ADMIN.				7,088	7,088	18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 119,393	$ * 119,393	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 2,337	$ 2,337	15
16	V	2	FOOD				4,524	4,524	16
17	V	6	MAINTENANCE				21	21	17
18	V	7	EMP. BEN. - GEN. SERV.				223	223	18
19	V	10	NURSING				3	3	19
20	V	17	ADMINISTRATIVE				118	118	20
21	V	19	PROFESSIONAL FEES				35	35	21
22	V	20	DUES, FEES, SUB.				9	9	22
23	V	21	CLERICAL & GENERAL				117	117	23
24	V	24	SEMINARS				7	7	24
25	V	25	TRAVEL				204	204	25
26	V	32	INTEREST				7	7	26
27	V	35	RENT - EQUIPMENT & VEHICLES				10	10	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				153	153	28
29	V	1	DIETARY SUPP	10,380			0	(10,380)	29
30	V	39	ANCILLARY SUPP	396			0	(396)	30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0							35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,776			$ 7,768	$ * (3,008)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	CLERICAL AND GENERAL	$	CARE CENTERS, INC.	100.00%	$ 0	$	15
16	V	27	EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0					0		17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICALSUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 24,528	$ 24,528	15
16	V									16
17	V									17
18	V									18
19	V	10	MEDICALSUPPLIES	29,180					(29,180)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			$ 29,180				$ 24,528	$ * (4,653)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 75,553	$ 75,553	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	75,553				(75,553)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 75,553			$ 75,553	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Steinberg	Owner	Administrative	2.00	See Attatched	2.49	4.98	Salary Alloc	$ 2,208	17-7	1
2	Eric Rothner	Owner	Administrative	31.43	See Attatched	2.44	3.39				2
3	Noah Wolff	Owner	Administrative	11.84	See Attatched	15	37.50				3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,208		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,512,231	32	$ 128,135	$ 128,055	75,279	$ 6,379	1
2	2	FOOD	PATIENT DAYS	1,512,231	32	(27,254)		75,279	(1,357)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,512,231	32	53,695	52,345	75,279	2,673	3
4	5	UTILITIES	PATIENT DAYS	1,512,231	32	41,192		75,279	2,051	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,512,231	32	337,107	220,731	75,279	16,781	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,512,231	32	51,593		75,279	2,568	6
7	10	NURSING	PATIENT DAYS	1,512,231	32	650,209	657,173	75,279	32,367	7
8	10A	THERAPY	PATIENT DAYS	1,512,231	32	125,600	125,524	75,279	6,252	8
9	11	ACTIVITIES	PATIENT DAYS	1,512,231	32	54,474	54,163	75,279	2,712	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,512,231	32	48,011	48,011	75,279	2,390	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,512,231	32	112,058		75,279	5,578	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,512,231	32	866,963	862,068	75,279	43,157	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,512,231	32	228,254		75,279	11,363	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,512,231	32	33,513		75,279	1,668	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,512,231	32	3,087,659	2,709,599	75,279	153,704	15
16	24	SEMINARS	PATIENT DAYS	1,512,231	32	119,372		75,279	5,942	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,512,231	32	5,310		75,279	264	17
18	26	INSURANCE	PATIENT DAYS	1,512,231	32	27,429		75,279	1,365	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,512,231	32	456,163		75,279	22,708	19
20	30	DEPRECIATION	PATIENT DAYS	1,512,231	32	288,068		75,279	14,340	20
21	32	INTEREST	PATIENT DAYS	1,512,231	32	311,903		75,279	15,527	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,512,231	32	55,780		75,279	2,777	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,512,231	32	106,673		75,279	5,310	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,512,231	32	87,772		75,279	4,369	24
25	TOTALS					$ 7,249,679	$ 4,857,669		$ 360,888	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		9	307,262	298,696		47,834	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		9	39,980			6,284	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		24	1,436,904	1,436,850		58,187	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		24	191,316			7,088	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,975,462	$ 1,735,546		$ 119,393	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,287,765	28	496,134	378,284	10,775	2,337	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,287,765	28	960,501		10,775	4,524	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,287,765	28	4,392		10,775	21	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,287,765	28	47,282		10,775	223	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,287,765	28	700		10,775	3	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,287,765	28	25,000		10,775	118	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,287,765	28	7,428		10,775	35	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,287,765	28	1,836		10,775	9	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,287,765	28	24,796		10,775	117	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,287,765	28	1,526		10,775	7	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,287,765	28	43,326		10,775	204	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,287,765	28	1,489		10,775	7	12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC.	2,287,765	28	2,182		10,775	10	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,287,765	28	32,397		10,775	153	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,648,989	$ 378,284		$ 7,768	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075			1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,476	$ 31,075		$	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION			$	$		$ 24,528	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 24,528	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 75,553	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 75,553	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	WHITE OAK NURSING CTR		X	MORTGAGE PAYABLE	$78,544.00	3/01/97	$ 7,441,383	$ 7,208,097	11/01/21	0.0120	$ 869,059	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DAIWA		X	WORKING CAPITAL				431,859			12,526	6
7												7
8												8
9	TOTAL Facility Related				$78,544.00		$ 7,441,383	$ 7,639,956			$ 881,585	9
	B. Non-Facility Related*											
10	Supplemental Schedule										35,661	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 35,661	14
15	TOTALS (line 9+line14)						$ 7,441,383	$ 7,639,956			$ 917,246	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
1	ALLOC-BLDG-ERIC R	X		WORKING CAPITAL			$	$			$ 27,494	1
2	Interest income										(7,360)	2
3	ALLOC - CCI	X		WORKING CAPITAL							15,527	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 35,661	21

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	269,040	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	250,305	2
3. Under or (over) accrual (line 2 minus line 1).	$	(18,735)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	259,905	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	15,000	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	256,170	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	243,551	8
	1996	255,356	9
	1997	261,872	10
	1998	256,204	11
	1999	247,528	12

2000 Accrual = 1999 tax $247,528 * 1.05 = $259,905 Rounded

Briar Place Tax expense $247,528 + $2,777 Allocated from Care Centers = $250,305.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,200 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 8,391 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 2,968 4. Dates Incurred: MARCH 1, 1997

Nature of Costs: ORGANIZATION COSTS, FINANCING FEES
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1997	$ 402,069	1
2	ALLOCATION - CCI		1996	3,186	2
3	TOTALS			$ 405,255	3

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1997		$ 7,041,541	$ 164,470	39	$ 164,470	$	$ 623,615	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	5,000	260	20	263	3	3,715	9
10	Various			1987	138,915	4,409	20	7,310	2,901	99,907	10
11	Various			1988	9,885	313	20	519	206	6,601	11
12	Various			1989	5,410	172	20	264	92	2,992	12
13	Various			1990	42,578	1,930	20	2,130	200	22,487	13
14	Various			1991	11,813	375	20	591	216	5,813	14
15	Various			1992	11,426	571	20	571		4,758	15
16	Various			1993	8,851	716	20	643	(73)	5,266	16
17	Various			1994	25,632	90	20	1,282	1,192	8,033	17
18	Various			1995	50,028	1,455	20	2,502	1,047	13,879	18
19	FIRE DOOR			1996	786	20	20	39	19	179	19
20	FIRE DOOR			1996	786	20	20	39	19	179	20
21	PAINT & DECORATING			1996	60,960	1,563	20	3,048	1,485	12,700	21
22	PLUMBING RENOV			1996	627	16	20	31	15	140	22
23	HVAC RENOV			1996	1,136	29	20	57	28	266	23
24											24
25	PAGE 12-1 REP TOTALS				70,978	1,889		2,354	465	9,455	25
26											26
27											27
28											28
29	PAGE 12G TOTALS				9,551	187		151	(36)	151	29
30	PAGE 12F TOTALS				103,244	4,572		2,322	(2,250)	2,322	30
31	PAGE 12E TOTALS				28,771	926		1,460	534	1,908	31
32	PAGE 12D TOTALS				132,480	3,921		6,657	2,762	17,710	32
33	PAGE 12C TOTALS				111,444	3,256		5,540	2,350	16,076	33
34	PAGE 12B TOTALS				107,393	3,723		6,033	2,310	20,298	34
35	PAGE 12A TOTALS				101,976	4,044		6,029	1,985	26,054	35
36	TOTAL (lines 4 thru 35)				$ 8,081,211	$ 198,927		$ 214,305	$ 15,470	$ 904,504	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER TRTMT SYS			1996	5,249	135	20	262	127	1,223	9
10	SIGN			1996	1,701	44	20	85	41	390	10
11	THERMOSTAT			1996	1,177	30	20	59	29	295	11
12	PLUMBING RENOV			1996	1,318	34	20	66	32	302	12
13	ELECTRICAL RENOV			1996	548	14	20	27	13	124	13
14	WATER HEATER			1996	2,070	53	20	104	51	485	14
15	WATER PUMP			1996	1,284	146	20	128	(18)	587	15
16	NEW ROOF			1996	42,300	1,085	20	2,115	1,030	8,989	16
17	HVAC RENOV			1996	3,000	77	20	150	73	750	17
18	HVAC RENOV			1996	2,299	59	20	115	56	537	18
19	HVAC RENOV			1996	605	16	20	30	14	132	19
20	BLDG RENOV			1996	3,685	94	20	184	90	813	20
21	PLUMBING RENOV			1996	5,085	130	20	254	124	1,122	21
22	PLUMBING RENOV			1996	543	14	20	27	13	135	22
23	PLUMBING RENOV			1996	1,700	44	20	85	41	368	23
24	PLUMBING RENOV			1996	815	21	20	41	20	181	24
25	NEW SIGN			1996	837	21	20	42	21	179	25
26	FIXTURES			1996	15,400	1,546	20	1,540	(6)	6,545	26
27	PLUMBING RENOV			1996	675	17	20	34	17	142	27
28	PUMP RENOV			1996	1,964	215	20	196	(19)	817	28
29	PLUMBING RENOV			1996	1,601	41	20	80	39	327	29
30	SIGN			1996	720	18	20	36	18	168	30
31	PLUMBING RENOV			1996	889	23	20	44	21	187	31
32	ELECTRICAL RENOV			1996	567	15	20	28	13	124	32
33	FLOOR RENOVATION			1996	784	20	20	39	19	172	33
34	WALLPAPER			1997	4,502	115	20	225	110	844	34
35	NURSE CALL SYS			1997	658	17	20	33	16	116	35
36	TOTAL (lines 4 thru 35)				$ 101,976	$ 4,044		$ 6,029	$ 1,985	$ 26,054	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			1997	2,415	62	20	121	59	424	9
10	HVAC RENOV			1997	646	17	20	32	15	99	10
11	WINDOW CRANKS			1997	507	13	20	25	12	85	11
12	WINDOWS			1997	515	13	20	26	13	91	12
13	ELECTRICAL RENOV			1997	1,707	44	20	85	41	298	13
14	BUILDING RENOV			1997	740	19	20	37	18	145	14
15	ROOM SIGNS			1997	4,031	464	20	403	(61)	1,478	15
16	PLUMBING RENOV			1997	585	15	20	29	14	97	16
17	DOOR SCREEN			1997	1,440	37	20	72	35	282	17
18	HVAC RENOV			1997	687	18	20	34	16	119	18
19	ELECTRICAL RENOV			1997	1,229	32	20	61	29	219	19
20	HVAC RENOVATION			1997	2,160	55	20	108	53	396	20
21	SHOWER RENOV			1997	1,300	33	20	65	32	238	21
22	WALLPAPER			1997	744	19	20	37	18	136	22
23	CUBICLE CURTAINS			1997	38,495	1,440	20	2,387	947	6,789	23
24	CARPETING			1997	6,895	177	20	345	168	1,294	24
25	WINDOW TREATMENT			1997	649	17	20	32	15	115	25
26	CARPET			1997	3,438	88	20	172	84	588	26
27	BUILDING RENOVATION			1997	975	25	20	49	24	188	27
28	DRYWALL INSTALL			1997	14,100	362	20	705	343	2,644	28
29	WINDOW TREATMENTS			1997	2,191	56	20	110	54	376	29
30	FLOOR RENOVATION			1997	1,150	29	20	58	29	218	30
31	CABELING			1997		154	20		(154)		31
32	PLUMBING RENOVATION			1997	580	15	20	29	14	111	32
33	HANDRAILS			1997	13,562	348	20	678	330	2,656	33
34	ALARM SYSTEM			1997	5,522	142	20	276	134	989	34
35	HVAC RENOVATION			1997	1,130	29	20	57	28	223	35
36	TOTAL (lines 4 thru 35)				$ 107,393	$ 3,723		$ 6,033	$ 2,310	$ 20,298	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINTING & DECOR			1997	6,700	172	20	335	163	1,228	9
10	FLOOR RENOVATION			1997	3,489	89	20	174	85	682	10
11	FLOOR RENOV			1997	2,348	60	20	117	57	380	11
12	PAINTING & DECOR			1997	750	19	20	38	19	149	12
13	SECURITY SYSTEM			1997	692	80	20	69	(11)	230	13
14	CERAMIC FLOOR			1997	525	13	20	26	13	85	14
15	CHANDELEIR			1997	744	19	20	37	18	114	15
16	PLUMBING RENOV			1997	8,543	219	20	427	208	1,317	16
17	WINDOWS			1997	1,631	42	20	82	40	273	17
18	WINDOW TREATMENT			1997	5,589	143	20	279	136	977	18
19	HVAC RENOVATION			1997	651	17	20	33	16	124	19
20	LANDSCAPING			1997	21,105	541	20	1,055	514	3,429	20
21	ROOF RENOV.			1998	9,250	237	20	463	226	1,196	21
22	HVAC REPAIR			1998	775	20	20	39	19	88	22
23	HVAC REPAIR			1998	693	18	20	35	17	76	23
24	FIRE ALARM SYS			1998	2,700	69	20	69	66	360	24
25	WINDOWS			1998	707	18	20	35	17	88	25
26	LANDSCAPING			1998	1,361	35	20	68	33	153	26
27	TILING			1998	6,315	162	20	316	154	711	27
28	LANDSCAPING			1998	10,125	260	20	506	246	1,265	28
29	ALARM			1998		389	20		(389)		29
30	TILES			1998	723	19	20	36	17	78	30
31	SPRINKLER SYSTEM			1998	1,360	35	20	68	33	147	31
32	HVAC RENOV			1998	17,362	445	20	868	423	2,242	32
33	ALARM			1998	2,026		20	101	101	227	33
34	ROOFING			1998	4,600	118	20	230	112	383	34
35	TILE REPLACEMENT			1998	680	17	20	34	17	74	35
36	TOTAL (lines 4 thru 35)				$ 111,444	$ 3,256		$ 5,540	$ 2,350	$ 16,076	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING RENOV			1998	16,500	423	20	825	402	2,338	9
10	NOMAI LITES			1998	805		20	40	40	120	10
11	FIRE ALARM UPGRADE			1998	730	19	20	37	18	108	11
12	HVAC RENOV			1998	2,225	57	20	111	54	259	12
13	FIRE ALARM SYS			1998	27,900	715	20	1,395	680	3,488	13
14	TILEING			1998	4,757	122	20	238	116	595	14
15	PLUMBING RENOV.			1998	1,355	35	20	68	33	204	15
16	CUBICLE CURTAINS			1998	909	23	20	45	22	131	16
17	AWNING			1998	1,891	48	20	95	47	230	17
18	TELEPHONE SYS			1998		381	20		(381)		18
19	LANDSCAPING			1998	4,054	104	20	203	99	474	19
20	WIRING			1998	640	123	20	64	(59)	149	20
21	HVAC RENOV			1998	11,089	284	20	554	270	1,570	21
22	ROOF RENOV			1998	32,500	833	20	1,625	792	4,604	22
23	FLOORING			1998	10,860	278	20	543	265	1,493	23
24	HVAC RENOV			1998	2,008	51	20	100	49	275	24
25	HVAC RENOV			1998	3,933	101	20	197	96	525	25
26	WALL MOUNT			1998	735	19	20	37	18	102	26
27	ELECTRICAL RENOV			1998	1,891	48	20	95	47	269	27
28	PLUMBING RENOV			1998	1,907	49	20	95	46	277	28
29	PIPING			1998	633	16	20	32	16	80	29
30	KITCHEN DRAIN			1999		35	20		(35)		30
31	HVAC			1999	1,065	27	20	53	26	84	31
32	SPRINKLER			1999	2,240	57	20	112	55	177	32
33	WATERPROOF SVCS			1999	900	23	20	45	22	64	33
34	HVAC			1999	953	24	20	48	24	68	34
35	DRAINS			1999		26	20			26	35
36	TOTAL (lines 4 thru 35)				$ 132,480	$ 3,921		$ 6,657	$ 2,762	$ 17,710	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MOTOR WORK			1999	1,243		20	62	62	78	9
10	WATER HEATERS			1999	7,485		20	374	374	499	10
11	WATER HEATERS			1999			20				11
12	POWER FOR TOASTER			1999	660		20	33	33	47	12
13	FAUCETS			1999	1,009		20	50	50	71	13
14	RECEIVER SYSTEM			1999	2,143	55	20	107	52	169	14
15	HVAC RENOVATION			1999	658	17	20	33	16	44	15
16	HVAC			1999	688	18	20	18		29	16
17	PHONE/SECURITY			1999			20				17
18											18
19	HVAC			1999	1,341	34	20	67	33	95	19
20	BRASS/CHROME HANDLES			1999	696		20	35	35	70	20
21				1999	1,907	49	20	95	46	182	21
22	PLUMBING RENOVATIONS			1999		15	20		(15)		22
23	CORNER GUARDS			1999	891	23	20	45	22	83	23
24	PLUMBING REPAIR			2000	701	16	20	32	16	32	24
25	PLUMBING			2000	1,006	16	20	33	17	33	25
26	BOILER REPAIRS			2000	975	24	20	49	25	49	26
27	HVAC			2000	511	12	20	26	14	26	27
28	CIRCUIT BREAKERS			2000	580	14	20	29	15	29	28
29	HVAC			2000	1,043	24	20	48	24	48	29
30	PAINTING			2000	1,286	29	20	59	30	59	30
31	PLUMBING REPAIR			2000	506	11	20	23	12	23	31
32	HVAC			2000	679	16	20	34	18	34	32
33	PLY PANELS			2000	809	162	20	61	(101)	61	33
34	LINEN CHUTE			2000	1,290	258	20	97	(161)	97	34
35	WINDOW REPAIR			2000	664	133	20	50	(83)	50	35
36	TOTAL (lines 4 thru 35)				$ 28,771	$ 926		$ 1,460	$ 534	$ 1,908	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	THERMOSTAT-ETC.			2000	1,737	348	20	58	(290)	58	9
10	RAIN VENT CAP			2000	618	124	20	41	(83)	41	10
11	EXHAUST FAN			2000	1,900	380	20	127	(253)	127	11
12	DOORS			2000	614	123	20	41	(82)	41	12
13	TANK & PUMP			2000	10,225	164	20	341	177	341	13
14	HVAC			2000	534	8	20	16	8	16	14
15	HVAC			2000	3,829	53	20	111	58	111	15
16	DOOR			2000	827	166	20	48	(118)	48	16
17	CUBICLE CURTAINS			2000	1,108	222	20	102	(120)	102	17
18	CABINETS			2000	712	143	20	41	(102)	41	18
19	CONCRETE PATIO			2000	6,233	47	20	104	57	104	19
20	ELEVATOR DOOR OPENER			2000	1,185	237	20	50	(187)	50	20
21	DRAIN			2000	887	11	20	22	11	22	21
22	HVAC			2000	857	8	20	18	10	18	22
23	CABLE			2000	3,176	635	20	133	(502)	133	23
24	ALARM			2000	814	163	20	34	(129)	34	24
25	CONDENSOR			2000	505	6	20	13	7	13	25
26	CIRCUIT			2000	2,500	500	20	104	(396)	104	26
27	DOOR CLOSER			2000	917	184	20	38	(146)	38	27
28	HVAC			2000	559	112	20	9	(103)	9	28
29	HVAC			2000	2,285	17	20	38	21	38	29
30	ELEVATOR			2000	50,875	272	20	636	364	636	30
31	FLOOD LIGHT			2000	510	102	20	17	(85)	17	31
32	PLUMBING			2000	6,300	47	20	105	58	105	32
33	HVAC			2000	1,069	6	20	13	7	13	33
34	FLOOD LIGHTS			2000	792	159	20	20	(139)	20	34
35	RELAY BOARD			2000	1,676	335	20	42	(293)	42	35
36	TOTAL (lines 4 thru 35)				$ 103,244	$ 4,572		$ 2,322	$ (2,250)	$ 2,322	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REWIRE SPEAKERS			2000	898	5	20	11	6	11	9
10	WATER HEATER			2000	7,450	40	20	93	53	93	10
11	HVAC			2000	524	6	20	13	7	13	11
12	WINDOWS			2000	679	136	20	34	(102)	34	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 9,551	$ 187		$ 151	$ (36)	$ 151	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			Alloc - CCI	1996	$ 56,383	$ 1,446	35	$ 1,611	$ 165	$ 6,578	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARE CENTERS, INC			2000	68	1	20	3	2	3	9
10	CARE CENTERS, INC			1999	1,010	26	20	51	25	96	10
11	CARE CENTERS, INC			1998	417	11	20	21	10	56	11
12	CARE CENTERS, INC			1997	5,914	135	20	326	191	1,581	12
13	CARE CENTERS, INC			1997	686	159	20	29	(130)	67	13
14	CARE CENTERS, INC			1996	6,500	86	20	313	227	1,074	14
15	CARE CENTERS, INC			1994		19	20		(19)		15
16	CARE CENTERS, INC			1993		6	20		(6)		16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 70,978	$ 1,889		$ 2,354	$ 465	$ 9,455	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,064,931	$ 267,578	$ 259,752	$ (7,826)		$ 243,143	37
38	Current Year Purchases	126,329	25,198	6,238	(18,960)		6,238	38
39	Fully Depreciated Assets	128,494	4,713	2,162	(2,551)		128,494	39
40								40
41	TOTALS	$ 1,319,754	$ 297,489	$ 268,152	$ (29,337)		$ 377,875	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	93 FORD VAN	1993	$ 47,238	$ 2,457	$ 3,555	$ 1,098		$ 36,845	42
43	CCI Allocation			26,782						43
44										44
45										45
46	TOTALS			$ 74,020	$ 2,457	$ 3,555	$ 1,098		$ 36,845	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 9,880,240	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 498,873	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 486,012	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (12,769)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,319,224	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

BRIAR PLACE, LTD.
0031765
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
CARE CENTER, INC	47,816	6,186	5,170	(1,016)	22,167
BRIAR PLACE	419,342	41,154	34,344	(6,810)	220,976
GWH LIMITED PARTNERSHIP	597,773	220,238	220,238		
TOTALS	1,064,931	267,578	259,752	(7,826)	243,143
LINE 29: CURRENT YEAR					
CARE CENTER, INC	2,694	463	63	(400)	63
BRIAR PLACE	123,635	24,735	6,175	(18,560)	6,175
GWH LIMITED PARTNERSHIP					
TOTALS	126,329	25,198	6,238	(18,960)	6,238
LINE 30: FULLY DEPRECIATED					
CARE CENTER, INC					
BRIAR PLACE	128,494	4,713	2,162	(2,551)	128,494
GWH LIMITED PARTNERSHIP					
TOTALS	128,494	4,713	2,162	(2,551)	128,494
TOTALS (Should Tie to Totals on Page 13)					
CARE CENTER, INC	50,510	6,649	5,233	(1,416)	22,230
BRIAR PLACE	671,471	70,602	42,681	(27,921)	355,645
GWH LIMITED PARTNERSHIP	597,773	220,238	220,238		
TOTALS	1,319,754	297,489	268,152	(29,337)	377,875

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A Related Party Lease
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		232		$			3
4	Additions							4
5		ALLOCATED FROM CCI			5,310			5
6								6
7	TOTAL		232		$ 5,310 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 10,205 Description: See Attatched Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$ 0	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 31,668	$		$ 31,668	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,289			13,289	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			40,584			40,584	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				33,880		33,880	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						41,131		41,131	13
14	TOTAL			$		$ 85,541	$ 75,011		$ 160,552	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	23,519
2	Air Fluid Beds	11,347
3	Radiology	1,838
4	Oxygen	664
5	Lab	694
6	Enterals	402
7	Respiratory Therapy	2,667
8		
9		
10		
		41,131

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

STATE OF ILLINOIS

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,584	$ 10,584	1
2	Cash-Patient Deposits	89,078	89,078	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,153,709	1,153,709	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	396,285	396,285	6
7	Other Prepaid Expenses	1,502	1,502	7
8	Accounts Receivable (owners or related parties)	(261,323)	(181,804)	8
9	Other(specify): See supplemental schedule	254,393	254,393	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,644,228	$ 1,723,747	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cos	913,231	913,231	15
16	Equipment, at Historical Cost	796,614	2,021,614	16
17	Accumulated Depreciation (book methods)	(737,461)	(2,192,793)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		8,391	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,433)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	3,588	3,588	22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 975,972	$ 7,563,981	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,620,200	$ 9,287,728	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,362,558	$ 1,362,558	26
27	Officer's Accounts Payable		253,651	27
28	Accounts Payable-Patient Deposits	86,273	86,273	28
29	Short-Term Notes Payable	431,859	431,859	29
30	Accrued Salaries Payable	194,966	194,966	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,094	22,094	31
32	Accrued Real Estate Taxes(Sch.IX-B)	259,905	259,905	32
33	Accrued Interest Payable		73,265	33
34	Deferred Compensation	939	939	34
35	Federal and State Income Taxes	(14,232)	(14,232)	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,344,362	$ 2,671,278	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,208,097	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,208,097	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,344,362	$ 9,879,375	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 275,838	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,620,200	$ #REF!	48

*(See instructions.)

Facility Name & ID Number BRIAR PLACE, LTD. **#** 0031765 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	157,901	157,901
Acrd Int. Recievable	31,492	31,492
Due From Others	65,000	65,000
	254,393	254,393

OTHER CURRENT LIABILITIES:	Amount	Amount

OTHER NON CURRENT ASSETS:

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 389,916	1	
2	Restatements (describe):		2	
3	Schedule attached		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 389,916	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	302,422	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(416,500)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (114,078)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 275,838	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	BRIAR PLACE, LTD.	#	0031765	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		389,916
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		389,916
Equity(Deficit) from Page 17 Col 1		275,838
Related Party		
Equity(Deficit)	-589999	
Income	-277485	
		(867,484)
Combined Equity - End of Year		(591,646)

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,599,347	1
2	Discounts and Allowances for all Levels	(418,588)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,180,759	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	355,737	6
7	Oxygen	3,113	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 358,850	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,083	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,741	19
20	Radiology and X-Ray	2,044	20
21	Other Medical Services	76,071	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 144,939	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,360	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,360	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	110	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 110	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,692,018	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,500,884	31
32	Health Care	2,646,412	32
33	General Administration	1,649,712	33
	B. Capital Expense		
34	Ownership	1,304,667	34
	C. Ancillary Expense		
35	Special Cost Centers	160,553	35
36	Provider Participation Fee	127,368	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,389,596	40
41	**Income before Income Taxes (line 30 minus line 40)****	302,422	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 302,422	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **BRIAR PLACE, LTD.** **# 0031765** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	JURY DUTY	52
2	MISC INCOME	34
3	UNIFORMS - MISC INCOME	24
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	110

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,672	1,825	45,972	25.19	2
3	Registered Nurses	22,355	25,282	529,235	20.93	3
4	Licensed Practical Nurses	23,968	28,229	485,901	17.21	4
5	Nurse Aides & Orderlies	87,329	102,910	905,534	8.80	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,147	4,732	51,419	10.87	8
9	Activity Director	1,855	1,988	23,274	11.71	9
10	Activity Assistants	11,087	12,079	97,726	8.09	10
11	Social Service Workers	9,422	10,440	141,353	13.54	11
12	Dietician	1,985	2,223	27,747	12.48	12
13	Food Service Supervisor	1,488	1,659	27,647	16.66	13
14	Head Cook	6,002	6,804	71,409	10.50	14
15	Cook Helpers/Assistants	22,573	24,359	160,770	6.60	15
16	Dishwashers					16
17	Maintenance Workers	7,530	7,919	141,157	17.83	17
18	Housekeepers	28,154	30,462	202,194	6.64	18
19	Laundry	12,401	13,437	118,728	8.84	19
20	Administrator					20
21	Assistant Administrator	1,976	2,281	42,284	18.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,133	9,499	107,334	11.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,754	2,506	33,027	13.18	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	253,831	288,634	$ 3,212,711 *	$ 11.13	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	483	$ 19,466	01-3	35
36	Medical Director	MONTHLY	9,000	09-3	36
37	Medical Records Consultant	MONTHLY	1,372	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	3,765	10-3	39
40	Physical Therapy Consultant	105	5,250	10A-3	40
41	Occupational Therapy Consultant	66	3,300	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	175	10A-3	43
44	Activity Consultant	51	2,240	11-3	44
45	Social Service Consultant				45
46	Other(specify) Utilization Review	MONTHLY	225	10-3	46
47	CCI Costs	See Attatched	71,425		47
48					48
49	TOTAL (lines 35 - 48)	709	$ 116,218		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	739	$ 29,996	3-10	50
51	Licensed Practical Nurses	1,457	47,303	3-10	51
52	Nurse Aides	1,649	36,654	3-10	52
53	TOTAL (lines 50 - 52)	3,845	$ 113,953		53

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrative salaries directly allocated from home office(see page 6			$
KRISTIN ZALESKI	ASST. ADMINISTRATOR		42,284
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 42,284

B. Administrative - Other

Description	Amount
CCI administrative payroll	$ 58,187
TOTAL (agree to Schedule V, line 17, col. 3)	$ 58,187
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE	LEGAL	$ 49,092
SEE ATTACHED SCHEDULE	COMPUTER-DATA PROCESS	15,282
CARE CENTERS, INC	ADMIN ANCILLARY SERV.	28,295
CARE CENTERS, INC	BOOKKEEPING SERVICES	48,102
CARE CENTERS, INC	ACCOUNTING	15,000
FROST, RUTTENBERG & ROTHB	ACCOUNTING	10,200
PERSONNEL PLANNERS, INC	UNEMPLOY CONSULTING	2,453
CARE CENTERS, INC	PA APPLICATIONS	7,665
MICHAEL D MILLER	MEDICARE COST REPORT	1,000
CARE CENTERS, INC	HOME OFFICE EXPENSE	198,065
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 375,154

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,033
Unemployment Compensation Insurance	48,431
FICA Taxes	241,820
Employee Health Insurance	164,954
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION EXP	4,136
EMPLOYEE PHYS	4,774
MISC EMP WELFARE	10,950
TOTAL (agree to Schedule V, line 22, col.8)	$ 574,098

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	21,661
Health Care Worker Background Check	2,076
(Indicate # of checks performed 173)	
DUES & SUBSCRIPTIONS	10,779
LICENSES, INSPECTIONS, AND PERMITS	31,423
PUBLIC RELATIONS	20,787
YELLOW PAGE ADVERT.	2,728
ALLOC - CCI	1,668
Less: Public Relations Expense	(20,787)
Non-allowable advertising	( )
Yellow page advertising	(2,728)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 67,807

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,794
EDUCATION EXPENSE	3,694
ALLOC - CCI	5,942
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,430

**See instructions.

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	6/94	$ 6,896	3	$ 1,149	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,896		$ 1,149	$	$	$	$	$	$	$	$

Facility Name & ID Number BRIAR PLACE, LTD. # 0031765 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC -$7,143**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **2,100** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **127,368**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit
on Schedule V. $ Has any meal income been offset against
related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw